EMERGENCY CONTRACEPTION PATIENT ASSESSMENT

Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth (Month / Day / Year): _____ /_____ /_____

Please answer the following questions:

1. When was the first day of your last menstrual period? Date *(Month / Day / Year)*:

   _____ /_____ /_____

2. Did your period come on time? ☐ Yes ☐ No

3. Was it the usual number of days and the usual amount of bleeding? ☐ Yes ☐ No

4. Why do you need emergency contraception?

   ☐ Recent unprotected sex or birth control failure

   ☐ Future need *(If only for future need, skip to question #6)*

5. Have you had unprotected sex during the last 5 days? ☐ Yes ☐ No

   If yes, when? Date *(Month / Day / Year)*: _____ /_____ /_____

6. Are you allergic to any medications or drugs? ☐ Yes ☐ No

   If yes, please list: _____

The following advice to the patient is optional:

- EC is for emergency use only. For regular, long-term use other methods of birth control are better and more effective. You should consult your health care provider for further information.
- If you have any of the following you may have a sexually transmitted infection (STI) and should see a doctor: burning when urinating, vaginal discharge/itch, pelvic pain, partner has a STI, abnormal vaginal bleeding, or pain during sex. You should consult your health care provider or your local public health clinic as soon as possible.

FOR PHARMACIST USE ONLY:

Client provided with:
- ☐ Key Facts Sheet
- ☐ EC Product
  - ☐ Plan B
  - ☐ Other _____

Referral Made for?
- ☐ *Contraception*
- ☐ *STI / HIV*
- ☐ *Pregnancy*
- ☐ *Primary Care*
- ☐ *Sexual Assault*
- ☐ *Child Abuse (Call DCYF 1-800-894-5533)*

Additional pharmacist notes/comments:

_____

_____

_____

Date: _____ / _____ / _____ Time: ____ : ____ AM / PM (Circle One) _____, *R.Ph.*

Pharmacist's Signature